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PROVIDER MANUAL: CHILD PLACING AGENCY RATES BULLETIN 2012-1

January 3, 2012

The following changes or additions are being made to the Provider Manual.

1) The following is added /revised in Ch. 2: Per Diem

Establishment of the Per Diem Payments and Annual Adjustment
In 2010, DCS entered into a contract with Ball State University to conduct a study to help DCS determine the reasonable costs of caring for a foster child in Indiana under Title IV-E. This information was used to assist in developing the four categories of supervision shown below. The Ball State study can be found at http://www.in.gov/dcs/2982.htm. To determine the rates for the four categories of supervision, DCS applied the cost-based findings of the Ball State study, as well as historical rate information from the various agencies that provide foster care services in Indiana. The Enhanced Supervision method, showing the categories of supervision, can be found at http://www.in.gov/dcs/2334.htm. In December, 2011, a cost of living adjustment was applied which slightly increased the original figures.

As a result, the per diem payment rates that will be paid to all foster parents for calendar year 2012 will be:

Category of Supervision	**Infant – 4 years**	**5 – 13 years**	**14 – 18 years**
Foster Care (maintenance payment)	$18.88	$20.51	$23.66
Foster Care with Services	$26.65	$28.28	$31.43
Therapeutic Foster Care	$38.79	$40.42	$43.57
Therapeutic Plus	$62.54	$64.17	$67.32
Non-ward baby[1]	+$18.88[2]	n/a	n/a

[1] If the baby is a ward, then the baby would be assessed using the CANS and would be assigned a rate based on their category of supervision.

2) The below replaces "Chapter 6: Behavioral Health."

Chapter 6: Behavioral Health[3]

General Information

Pursuant to the CPA rate rule, behavioral health services are unbundled from the maintenance and administrative payment to the CPA so that actual costs are identifiable and alternative funding sources can be accessed to enable the most efficient use of state funds to pay for child services. As such, the department will refer separately for behavioral health services to CPAs or other behavioral health providers who are able to bill Medicaid and who have a contract with the department. The referral given at the time of placement authorizes the provider to provide the service. Providers do not have to wait until Medicaid approves units to start performing the services. If the child is not Medicaid eligible or Medicaid denies the approved service, then DCS will pay based on the initial referral. CPAs can collaborate with other providers to provide Medicaid services with reference to behavioral health services.

Effective January 1, 2012, for children who are Medicaid eligible, behavioral health costs shall be billed to Medicaid for services authorized by the department that are Medicaid eligible. For services that are not covered by Medicaid but are authorized by the department, the department will pay through a contract with the provider. When the department makes a referral for behavioral health services to the CPA, the referred counseling units will include both Medicaid billable units and DCS billable units. DCS will only pay for counseling sessions that are denied by Medicaid. The referred units should not be interpreted to limit the amount of units billed to Medicaid, but serve as a cap as to what can be billed to DCS. The department will also refer units, for billing to the department without first billing Medicaid, for when the therapist is requested by the department to write court reports and attend child and family team meetings and court.

The CPA is required to first bill Medicaid for the Medicaid eligible referred services and request Prior Authorization. If the initial 20 Medicaid units are used and PA is denied, the provider can bill DCS if the number of units on the referral has not been maximized by Medicaid billings. The number of units listed on the referral will be for six (6) months. NOTE: If a PA is initially denied and later there are changed circumstances involving the child that would necessitate medically necessary behavioral health (e.g. a critical case juncture), the CPA is expected to request another PA from Medicaid.

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[2] $18.88 will be added to the teen mom's per diem for a non-ward baby. The teen mom's per diem will be determined by DCS with the assistance of the CANS assessment tool.

[3] The department will pay the state match for Medicaid Rehabilitation Option services paid by Medicaid on behalf of department and probation youth placed in CPA foster care. Any state match related to Medicaid-eligible services will be paid directly to the community mental health center (CMHC) if the CMHC is providing services on behalf of a CPA that has a CPA master contract with the department. There is no match for services paid with state dollars.

If the child is not Medicaid eligible and if private insurance is not available or does not cover the costs of services or treatment, behavioral health costs that are referred by the department shall be billed to the department through the CPA's contract with the department.

For new placements made on or after January 1, 2012, the department shall refer therapy to the CPA as part of the placement for children in therapeutic and therapeutic plus categories if the CPA has a contract with the department for therapy, unless it is in the child's best interest to be referred to a different behavioral health provider. If the department refers therapy to the CPA but the child is also eligible for Medicaid Rehabilitation Option (MRO) services, the department will also make a referral to a community mental health center (CMHC) for additional MRO services. For CPAs who have a contractual relationship with a CMHC to provide behavioral health services to children in CPA foster homes, the department expects the CPA and CMHC to provide the additional MRO services. A referral for MRO service will not be needed.

The department will utilize the CANS assessment to assist in determining the appropriate behavioral health services for the child.

For placements made before January 1, 2012 and remaining in placement on or after January 1, 2012, the department shall refer to the existing therapist for continuity and consistency in therapeutic relationships unless it is in the child's best interests to be referred to a different behavioral health provider. If it is in the child's best interest to be referred to a different behavioral health provider, the department will develop a transition plan in consultation with the CPA.

All behavioral health services must be completed in accordance with service standards set by the department. The services standards can be found on the department's website at www.in.gov/dcs.

Medicaid Enrollment for Wards of the Department and Probation

When a child is placed in an out of home placement, the family case manager or probation officer is required to run Title IV-E eligibility in the appropriate data system. This can take anywhere from a few days to 30 days. Once this occurs, the department's Medicaid Enrollment Unit (MEU) is able to generate a report of IV-E and non-IV-E eligible children.

If the child is IV-E eligible, MEU enrolls the child in MA 4 (a type of Medicaid). This process takes only a few days. If the child is non-IV-E eligible, MEU refers the child to the Division of Family Resources with a Medicaid application. This process takes 2 weeks to 45 days. Thus, the entire Medicaid enrollment process can take from just a week up to 75 days.

When there are changes in placement or IV-E eligibility or a reunification, Trial Home Visit or case closure, MEU receives a report and makes appropriate Medicaid changes. For DFR redeterminations, MEU receives the notices from DFR, requests information from the family case manager or probation officer and communicates eligibility information back to DFR, so there are no lapses in Medicaid coverage.

For issues with Medicaid eligibility, contact the family case manager or probation officer assigned to the child's case. They will then contact MEU for assistance.

3) The following is added / revised in Chapter 8: Invoicing and Billing

All invoices, including those for payments that will be passed through to the CPA foster parent, must be signed by the CPA as the department's contract is with the CPA, not the CPA foster parent.

The billable unit ID from the referral must be entered on the invoice. It is not necessary to add the person ID to the invoice when invoicing the daily per diem, initial clothing and personal allowance. For the special occasion allowance, a referral will not be generated, thus there is no billable unit ID for the invoice. Instead, you will invoice with the person ID only (this is the child's person ID which is located at the bottom of the ICPR for the placement).

When invoicing travel for visitation, the claimable mileage depends on the length of the visit.

a. If the visit is for two (2) hours or less, one (1) round trip may be claimed (i.e. from home to the visitation location and back to home).
b. If the visit is for more than two (2) hours, the foster parent may claim two (2) round trips from home to the visitation location ,i.e. 1) from home to the visitation location and back home for drop off and 2) from home to the visit location and back home for pick up) . If the foster parent travels somewhere other than home between drop off and pick up for visitation, the foster parent must claim this travel if it is a shorter distance. For example, if the foster parent drops off the child at visitation and drives to the shopping mall, which is 10 miles closer to visitation than their home, then the foster parent must claim the shorter distance.

Instructions for Completing the Invoice

The following are instructions for completion of your invoice. The line numbers below coincide with item numbers on the claim form (NOTE: the below instructions are for the new Claim for Support of Children form that is available on the DCS website on 1/1/12; a claim using the old version of the form will still be processed):

1. *NAME – Legal name of benefit/product/service provider; must match name submitted via the Vendor Information Form.
2. *TAX IDENTIFICATION NUMBER – The Federal Tax Identification Number associated with the legal name in Section 1. This is your Social Security Number for individuals.
3. *ST NUMBER - State Vendor ID # assigned by the DCS payment system (KidTraks). This 6 digit number can be found on the Warrant Summary. ST Numbers are also available at http://financials.dcs.in.gov/login.aspx. From there, select "Provider Service Guide" and enter your Tax ID in the appropriate space provided.
4. *INVOICE NUMBER NO LONGER THAN 8 Digits/Letters– assigned by the vendor; this should be a unique number for each submission and can include letters and/or numbers (e.g. "Nov2010" or "1001").

5. *DATE OF INVOICE – Date assigned by the vendor as the date of the claim; cannot be prior to the most recent date of service on the invoice. Invoices must be received by DCS KidTraks Invoicing within 10 business days of this date.
6. *ADDRESS – Vendor's complete address, which should match the most recent Vendor Information form on file.
7. *INVOICE TYPE - Is the invoice being submitted the first submission, a re-bill due to denial of past invoice lines or an appeal of denied lines of services provided?
8. *PAGE NUMBER – Includes the current page number as well as the total number of pages included in the Claim (limited to a total of 3 pages per Invoice).
9. *INVOICE SERVICE TYPE - Only one overriding service type should be selected for all service codes being invoiced in column 16. The invoice service type should reflect all services being invoiced.
10. *FOR THE PERIOD – The first and last days of the month being billed on the Claim. (e.g. January services would be: From January 1, 2011 to January 31, 2011). The Claim period should not be confused with the Dates of Service (Sections 17 & 18) as vendors may list multiple children/Case #s/Referral IDs with different dates of service during the Claim period.
11. *TOTAL OF CLAIM – The cumulative sum of the Total Cost columns (col. 21) of all invoice pages carried-out 2 digits. This is the total cost of all (up to 3) of the invoice pages. This total cannot be adjusted upward once it's been submitted.
12. *COUNTY – Name of County that authorized services to be rendered for the child being served. For *Post Adoption or Independent Living services, please enter County of child's residence.* NOTE: An invoice can include line items for multiple counties.
13. *CASE #/BILLABLE UNIT ID – The Case Number assigned by DCS per the old Excel referral OR the Billable Unit Referral ID from the new Wizard referral.
14. *PERSON ID – This is the child's wardship number in KidTraks and is required for all provider invoices for individual services by Case Number per the old Excel referral.
15. NAME IN FULL – Name of person receiving benefit/product/service.
16. *SERVICE CODE – (a.k.a. Billing Code) represents the benefit/product/service provided. Provider codes are available at http://financials.dcs.in.gov/login.aspx From there, select "Provider Service Guide" and enter your Tax ID or DCS Vendor ID (i.e. ST Number) in the appropriate space provided.
17. *BEGIN DATE OF SERVICE – First day the benefit/product/service was provided. If the service was provided in one day, the Begin Date and End Date will be the same. EG. Daycare, Day Treatment New process
18. *END OF DATE OF SERVICE – Last day the benefit/product/service was provided. If the service was provided in one day, the Begin Date and End Date will be the same.

19. *UNIT – The number of times a benefit/product/service was rendered during the Claim period. Units are defined in contracts/agreements and are typically 15-minute or 1-hour increments for services such as counseling; days for residential & Homebuilders.
20. *RATE – The amount (carried-out 2 digits) per unit for which a benefit/product/service is rendered per the contract/agreement.
21. *TOTAL COST – The total amount of the line item calculated by multiplying the number of units by the rate (Unit x Rate=Total Cost) carried-out 2 digits.
22. *SIGNATURE OF VENDOR – Authorizing signature of vendor submitting the Claim. All pages submitted must be signed; blue ink is strongly recommended.
23. * TELEPHONE NUMBER OF VENDOR - Telephone number for Vendor, to be used only for clarifications and resolution of billing issues.
24. *E-MAIL ADDRESS OF VENDOR – E-mail address of authorizing vendor submitting the Claim. Provider e-mail address should be to fiscal staff who can respond to questions/issues.
25. *DATE – This is the date the invoice was completed/signed. This date cannot be before the last day of service.

Failure to follow the above guidelines could result in the claim being denied and/or returned for correction. Invoices must be mailed to:

DCS KidTraks Invoicing
Room W364, Mail Stop 54
402 W. Washington Street
Indianapolis, IN 46204-2739

4) The following is added /revised in Ch. 10: Request for Review of the Child's Category of Supervision at Initial Placement and Thereafter

A request by a CPA for review of the child's category of supervision for reasons outlined in this Provider Manual in accordance with the administrative rule must be submitted timely and in writing to the local office director or chief probation officer in the county of the child's case.

When a request for a review of the category of supervision is received, , the local office director or chief probation officer (or their designee) will hold a meeting with the CPA and their foster parent to discuss the needs of the child within 14 calendar days of the request for review. It is mandatory that a CPA representative as well as the foster parent attend this meeting as both parties will have relevant information regarding the child's strength and needs. The family case manager or probation officer should also be in attendance at this meeting. If the foster parent and/or CPA do not attend the meeting, the department will conduct a paper review.